

GEORGIA DEATH CERTIFICATE

State File Number 2023GA000030724

1. DECEDENT'S LEGAL FULL NAME (First, Middle, Last) <b>LEBRON SPATES DALLAS</b>		1a. IF FEMALE, ENTER LAST NAME AT BIRTH		2. SEX <b>MALE</b>	2a. DATE OF DEATH (Mo., Day, Year) <b>ACTUAL DATE OF DEATH 05/06/2023</b>
3. SOCIAL SECURITY NUMBER <b>-9084</b>	4a. AGE (Years) <b>50</b>	4b. UNDER 1 YEAR Mos. Days Hours Mins.	4c. UNDER 1 DAY Hours Mins.	5. DATE OF BIRTH (Mo., Day, Year) <b>1972</b>	
6. BIRTHPLACE <b>TENNESSEE</b>	7a. RESIDENCE - STATE <b>GEORGIA</b>	7b. COUNTY <b>WALKER</b>	7c. CITY, TOWN <b>LAFAYETTE</b>		
7d. STREET AND NUMBER <b>1 S STEELE STREET</b>	7e. ZIP CODE <b>30728</b>	7f. INSIDE CITY LIMITS? <b>YES</b>	8. ARMED FORCES? <b>NO</b>		
8a. USUAL OCCUPATION <b>DISABLED</b>		8b. KIND OF INDUSTRY OR BUSINESS <b>DISABLED</b>			
9. MARITAL STATUS <b>DIVORCED</b>	10. SPOUSE NAME		11. FATHER'S FULL NAME (First, Middle, Last) <b>JAMES DALLAS</b>		
12. MOTHER'S MAIDEN NAME (First, Middle, Last) <b>CAROLYN SPATES</b>	13a. INFORMANT'S NAME (First, Middle, Last) <b>CAROLYN SPATES</b>		13b. RELATIONSHIP TO DECEDENT <b>MOTHER</b>		
13c. MAILING ADDRESS <b>1796 DONWOODY ROAD LAFAYETTE GEORGIA 30728</b>		14. DECEDENT'S EDUCATION <b>SOME COLLEGE CREDIT LEADING TO A BACHELOR'S DEGREE</b>			
15. ORIGIN OF DECEDENT (Spanish/Hispanic/Latino) <b>NO, NOT SPANISH/HISPANIC/LATINO</b>		16. DECEDENT'S RACE (White, Black, American Indian, etc.) (Specify) <b>BLACK OR AFRICAN-AMERICAN</b>			
17a. IF DEATH OCCURRED IN HOSPITAL		17b. IF DEATH OCCURRED OTHER THAN HOSPITAL (Specify) <b>NURSING HOME-LONG TERM CARE FACILITY</b>			
18. HOSPITAL OR OTHER INSTITUTION NAME (If not in either give street and no.) <b>FRUITT HEALTHCARE OF FT. OGLETHORPE</b>		19. CITY, TOWN or LOCATION OF DEATH <b>FORT OGLETHORPE</b>		20. COUNTY OF DEATH <b>CATOOSA</b>	
21. METHOD OF DISPOSITION (specify) <b>BURIAL</b>		22. PLACE OF DISPOSITION <b>LAFAYETTE CEMETERY 103 SHAW STREET N LAFAYETTE GEORGIA 30728</b>		23. DISPOSITION DATE (Mo., Day, Year) <b>05/13/2023</b>	
24a. EMBALMER'S NAME <b>WILLIAM JAMES WILLIS, JR</b>		24b. EMBALMER LICENSE NO. <b>2383</b>		25. FUNERAL HOME NAME <b>WILLIS FUNERAL HOME</b>	
25a. FUNERAL HOME ADDRESS <b>2011 MARTIN LUTHER KING JR. BLVD DALTON GEORGIA 30721</b>		26a. SIGNATURE OF FUNERAL DIRECTOR <b>WILLIAM J WILLIS</b>			
27. DATE PRONOUNCED DEAD (Mo., Day, Year) <b>05/06/2023</b>		28. HOUR PRONOUNCED DEAD <b>05:15 PM</b>		29b. LICENSE NUMBER <b>RN113257</b>	
29a. PRONOUNCER'S NAME <b>Tracy ANZELEE RICE Cochran</b>		29c. DATE SIGNED <b>05/06/2023</b>		30. TIME OF DEATH <b>05:15 PM</b>	
31. WAS CASE REFERRED TO MEDICAL EXAMINER <b>NO</b>		32. Part I. Enter the date of events, diseases, injuries, or complications that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventilator withdrawal without knowing the etiology. DO NOT ABBREVIATE.  IMMEDIATE CAUSE (Final disease or condition resulting in death)  A. <b>ACUTE KIDNEY FAILURE</b> Due to, or as a consequence of B. <b>HEPATIC ENCEPHALOPATHY</b> Due to, or as a consequence of C. <b>ALCOHOLIC CIRRHOSIS OF LIVER</b> Due to, or as a consequence of D.  Part II. Enter significant conditions contributing to death but not related to cause given in Part I. A. If female, indicate if pregnant or birth occurred within 90 days of death. <b>ANEMIA, HISTORY OF COVID</b>			
33. WAS AUTOPSY PERFORMED? <b>NO</b>		34. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH?			
35. TOBACCO USE CONTRIBUTED TO DEATH <b>UNKNOWN</b>		36. IF FEMALE (range 10-54) PREGNANT <b>NOT APPLICABLE</b>		37. ACCIDENT, SUICIDE, HOMICIDE, UNDETERMINED (Specify) <b>NATURAL</b>	
38. DATE OF INJURY (Mo., Day, Year)		39. TIME OF INJURY		40. PLACE OF INJURY (Home, Farm, Street, Factory, Office, Etc.) (Specify)	
41. INJURY AT WORK? (Yes or No)					
42. LOCATION OF INJURY (Street, Apartment Number, City or Town, State, Zip, County)					
43. DESCRIBE HOW INJURY OCCURRED					
44. IF TRANSPORTATION INJURY					
45. To the best of my knowledge death occurred at the time, date and place and due to the cause(s) stated. Medical Certifier (Name, Title, License No.) <b>BYRON A LITTLEFIELD, DO, 28810</b>					
46. On the basis of examination and/or investigation, in my opinion death occurred at the time, date and place and due to the cause(s) stated. Medical Examiner/Coroner (Name, Title, License No.)					
45a. DATE SIGNED (Mo., Day, Year) <b>05/10/2023</b>		45b. HOUR OF DEATH <b>05:15 PM</b>		45c. DATE SIGNED (Mo., Day, Year)	
45d. HOUR OF DEATH					
47. NAME, ADDRESS, AND ZIP CODE OF PERSON COMPLETING CAUSE OF DEATH <b>BYRON A LITTLEFIELD 21 COMMERCE PARKWAY ADAIRSVILLE GEORGIA 30103</b>					
48. REGISTRAR (Signature) <b>/S/ CHRISTOPHER JP HARRISON</b>		49. DATE FILED - REGISTRAR (Mo., Day, Year) <b>05/10/2023</b>			